

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 48B

CERTIFICATE OF DEATH

06020, 183
Reg. Dist. No.

1. PLACE OF DEATH: Harford
 County Taylor
 City or town (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 weeks
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

3. (a) FULL NAME Henrietta Adams
 4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced Widow
 6. (b) Name of husband or wife John H. Adams
 7. Birth date of deceased (mo., day, yr.) Sept 23 1872 8. (c) If alive, give age years
 8. AGE: 73 Years 9 Months 7 Days If less than one day hrs. min.
 9. Birthplace Rocky Harford co md (Town, county, and state)
 10. Usual occupation House wife
 11. Industry or business
 MOTHER FATHER
 12. Name Samuel Harmon
 13. Birthplace Penna
 14. Maiden name Elizabeth Smeltzer
 15. Birthplace Penna
 16. Informant J Roy Adams
 Address White Hall md
 17. Burial Burial Date thereof July 27 46 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory St Paul
 Location Pylesville
 18. Funeral director Marta E. Kutz
 Address Jarretsville md
 19. Date record by registrar July 3rd 1946 Thomas P. Brown
 (Date record by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State MD County Harford
 City or town White Hall Rd. (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____ (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH JUN 30 1946 at 20 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1943 to JUN 30 1946and that I last saw her alive on June 30 1946Immediate cause of death Carbuncle of uterus DURATION _____

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE J. W. France M. D. or other _____Address Parkton, Md. Date signed 7/1/46



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

06021

Reg. Dist. No. 183

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

9-45

VS A15

1. PLACE OF DEATH:

County

Harford

City or town

Garretttsville (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

46 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Martha Ellen Bevard

4. Sex

F.

5. Color or race

white

6. (a) Single, married, widowed, or divorced

widow

6. (b) Name of husband or wife

George T. Bevard

7. Birth date of deceased (mo., day, yr.)

Jan. 19, 1869

8. (c) If alive, give age years

8. AGE:

77

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Garretttsville, Md.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Elijah Rockhold

12. Name

Harford Co. Md

13. Birthplace

Margaret Ayres

14. Maiden name

Harford Co. Md

15. Birthplace

Samuel T. Bevard

16. Informant

Rocke, R.D. Md

Address

17. Burial

Date thereof June 22, 1946

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Bethel

Location

Madonna, Md.

18. Funeral director

Martin G. Kurt

Address

Garretttsville, Md.

19. Date rec'd by registrar

Thomas P. Brown

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Harford

City or town

Garretttsville (rural)

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 19,

1946

at 12:15 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

January

1946

to June 19

1946

and that I last saw her alive on June 19 1946

Immediate cause of death

I

had

pneumonia

DURATION

3 days

Due to Cerebral vascular accident with paralysis to one side

Due to Hypertension cardiac

vascular disease

2 years

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

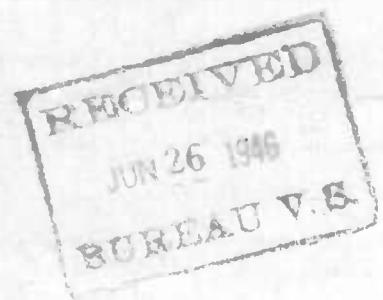
Charles A. Jeff

Md

Address

Street, Md

Date signed 6-20-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

STATE OF MARYLAND

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 132

CERTIFICATE OF DEATH

06022

Reg. Dist. No.

185-

1. PLACE OF DEATH: Hanford
 County Hanford
 City or town Hanford Grace
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 28 yrs
 Hospital, institution, or street address where death occurred: 659 Green St
 How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Md. County Hanford
 City or town Hanford Grace
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 659 Green St.
 (If rural, give LOCATION)

3. (a) FULL NAME

Nellie Starr Bonney 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Charles P. Bonney

7. Birth date of deceased (mo., day, yr.) Aug. 20 1872 6. (c) If alive, give age — years

8. AGE: 73 Years 10 Months 4 Days If less than one day — hrs. — min.

9. Birthplace Wilmington Del.
 (Town, County, and state)

10. Usual occupation House Duties

11. Industry or business Thoses Bracken Starr

FATHER 12. Name Thoses Bracken Starr
 13. Birthplace Del.

MOTHER 14. Maiden name Mary A. Knott
 15. Birthplace Del.

16. Informant Mr. Charles P. Bonney
 Address 659 Green St. City

17. Burial Angels Dell
 (Burial, cremation, or removal. Which?) Funeral 27.1946
 Date thereof Funeral 27.1946
 (month) (day) (year)

Cemetery or crematory Angels Dell
 Location Hanford Grace Md.

18. Funeral director T. Madison Mitchell
 Address Hanford Grace Md.

19. Date rec'd by registrar June 26 1946
 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 24 1946 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19, to 19.

and that I last saw h. alive on —

Immediate cause of death Arteriosclerotic C V Disease
 Due to —
 Due to —

Other conditions —
 (Include pregnancy within 8 months of death)

Major findings of operations —
 Date of op. —

Autopsy results —
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

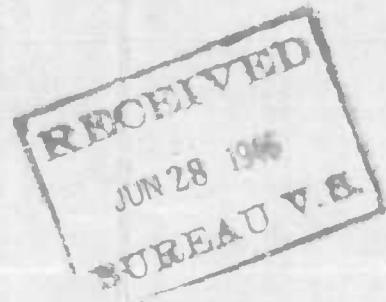
Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) — (County) — (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE Donald C. Palmer M.D.
 Deputy Medical Examiner
 Address Hanford County Md. M. D. or other —
 Date signed 6/25/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06023

942

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH:

County HarfordCity or town Bel Air, Rural
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 6 yearsHospital, Institution, or street address where death occurred: Harford Co. Home

How long in hospital or institution?

3. (a) FULL NAME

Frank Caponic4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced S6. (b) Name of husband or wife: ✓7. Birth date of deceased (mo., day, yr.) Oct 1 - 1874 8. (c) If alive, give age years8. AGE: Years 71 Months Days If less than one day hrs. min. 9. Birthplace Harford Co., Md.
(Town, county, and state) ✓10. Usual occupation:

11. Industry or business

12. Name Franklin Caponic13. Birthplace Germany14. Maiden name Maudie Sprader15. Birthplace Germany16. Informant Harford Co. (Records)Address Bel Air, Md.17. Burial Burial Date thereof June 5/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Harford Co. Home -Location Bel Air, Md. Rural18. Funeral director Dunn & FosterAddress Bel Air, Md.19. 6/5 Date rec'd by registrar 1946 Priscilla Lovwood
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County HarfordCity or town Bel Air, Rural
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH June 421. I CERTIFY that death occurred on the date above stated; that I attended deceased from not treated previously and that I last saw him alive on June 4 1946.

Immediate cause of death

Coronary Thrombosis

DURATION

Severe
Death
1 hrDue to: Due to: Other conditions:

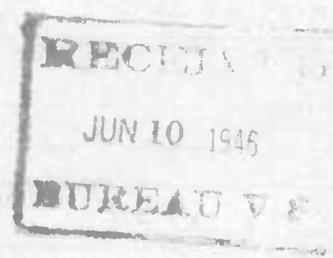
(Include pregnancy within 3 months of death)

Major findings of operations: Date of op. Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of: Where did injury occur? (City or town) (County) (State) Injured at home, farm, industry, public place (where?) Means of injury Injured at work? 23. SIGNATURE Wheeler P. Hudson M. D. or other Address Forest Hill, Md. Date signed 6/5/46



RECEIVED

JUL 3 1946

BUREAU V E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CITY AND CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-14

CERTIFICATE OF DEATH

06025

Reg. Dist. No. 185-

1. PLACE OF DEATH: Harford
County.....

City or town Harve de Grace
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
825 So. Market St.

How long in hospital or institution?

3. (a) FULL NAME Alice Chesney

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife John Benj. Chesney

7. Birth date of deceased (mo., day, yr.) Sept. 14, 1852 6. (c) If alive, give age _____ years

8. AGE: Years 93 Months 9 Days 7 If less than one day _____ hrs. _____ min.

9. Birthplace Harford Co. Md. (Town, county, and state)

10. Usual occupation House Duties

11. Industry or business Retired 30 yrs.

12. Name Elijah Thompson

13. Birthplace Md.

14. Maiden name Martha Forsythe

15. Birthplace Md.

16. Informant Mrs. Grace Lee Turner

Address 825 So. Market St., City

17. Burial Burial Date thereof June 23, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Wesleyan Chapel

Location Harford Co., Md.

18. Funeral director H. Madison Mitchell

Address Harve de Grace, Md.

19. Date rec'd by registrar June 22 1946

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Harford

City or town Harve de Grace
(If outside city or town limits, write RURAL and give nearest town)

Street No. 825 So. Market St.
(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (b) Social Security Number _____

MEDICAL CERTIFICATION

20. DATE OF DEATH June 21, 1946 at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 16, 1944 to June 21, 1946

and that I last saw her alive on June 20, 1946

Immediate cause of death Cerebral Hemorrhage

Due to Arterio Sclerosis

Due to Chronic Hypertension

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

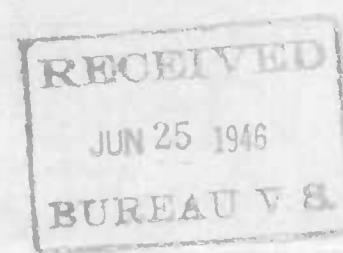
Where did injury occur? _____ (City or town) _____ (County) _____ (State)

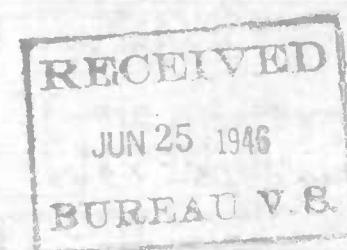
Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Asley MD M. D. or other _____

Address Harve de Grace, Md. Date signed 6-22-46





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *MD*

CERTIFICATE OF DEATH

06027/180
Reg. Dist. No.

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Charles Edward Christopher Jr

4. Sex

m

5. Color or race

w

6. (a) Single, married, widowed, or divorced

single

6. (b) Name of husband or wife

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

8 - 19 - 1886

8. AGE:

Years
60

Months

Days

If less than one day

hrs. min.

9. Birthplace

Balt Md
(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name Charles E Christopher

13. Birthplace Balt Md

14. Maiden name Mary A Chamberlain

15. Birthplace Md

16. Informant Mrs Nellie Phelps

Address Gaffa Md

17. Burial, cremation, or removal. Which? Date thereof 6-10-46

(month) (day) (year)

Cemetery or crematory Oaklawn

Location Balt Md

18. Funeral director L. W. Hodson

Address 5305 Edgewood Rd.

19. 6/8 1946 A. W. Hodson

(Date rec'd by registrar) (Signature) (Registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Balt

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

Balt

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 7 1946 at 8:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 18 1946 to June 7 1946

and that I last saw him alive on June 6 1946

Immediate cause of death

cardios of the Liver

Due to not known

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Fred O Hodson, M.D.

M. D. or other

Address Edgewood, Md. Date signed 6-7-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06028

182

Reg. Dist. No. 182

1. PLACE OF DEATH: Harford
 County: Wardington
 City or town: Wardington (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

3. (a) FULL NAME Geo. P. Cook
 4. Sex Male Color or race White 6. (a) Single, married, widowed, or divorced Single
White Dingle
 6. (b) Name of husband or wife Mr
 7. Birth date of deceased (mo., day, yr.) Jan. 18, 1855 6. (c) If alive, give age years
 8. AGE: 91 Years 5 Months 12 Days 1 If less than one day hrs. min.
 9. Birthplace Harford Co., Md. (town, county, and state)
 10. Usual occupation Farmer
 11. Industry or business Dairy
 MOTHER FATHER 12. Name Joel Cook
 13. Birthplace Penna
 14. Maiden name Martha Reason
 15. Birthplace Penna
 16. Informant Mr Charles Cook
 Address 227 A. Monroe St. Brooklyn
 17. Burial Date thereof July 3 1946 (month) (day) (year)
 (Burial, cremation, or removal. Which?) Cemetery or crematory Wardington Cem
 Location Harford Co., Md.
 18. Funeral director A. S. Bailey
 Address Wardington, Md.
 19. Date rec'd by registrar July 1 1946 M. D. or other M. C. Kirk
 Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
 State Md County Harford
 City or town Wardington (If outside city or town limits, write RURAL and give nearest town)
 Street No. Mr (If rural, give LOCATION)

2. (a) If veteran, name war Mr3. (b) Social Security Number Mr

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 194621. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1 1946 to June 30 1946 and that I last saw him alive on June 28 1946Immediate cause of death Coronary EndocarditisDue to Enlarged prostate DURATION 1 yr

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

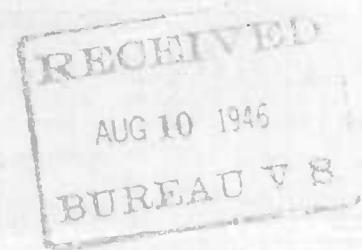
Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. E. Sallion M. D. or otherAddress Wardington Date signed 6/30/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1950

CERTIFICATE OF DEATH

06029

8

Reg. Dist. No. 185

1. PLACE OF DEATH: Harford
 County.....
 City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Harford Memorial Hospital

How long in hospital or institution?

3. (a) FULL NAME

Allan O. Evelyn

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married8. (b) Name of husband or wife Ada C. Evelyn7. Birth date of deceased (mo., day, yr.) February 14, 18818. AGE: Years 65 Months 5 Days 22 If less than one dayhrs. 0 min. 09. Birthplace Barbados, British West Indies

(Town, county, and state)

10. Usual occupation Hull Inspector11. Industry or business Edward Evelyn12. Name Edward Evelyn13. Birthplace British West Indies14. Maiden name Sarah E. Roach15. Birthplace British West Indies16. Informant Mrs Ada C. EvelynAddress 222 Detroit Ave. Dundalk17. Burial Date thereof June 8, 1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory OaklawnLocation Eastern Avenue18. Funeral director Roland L. FisherAddress 2112 Dundalk Ave. Dundalk19. 6-7 46 (Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County BaltimoreCity or town Dundalk

(If outside city or town limits, write RURAL and give nearest town)

Street No. 222 Detroit Avenue

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH June 5, 1946

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. — to —

19.

and that I last saw h. — alive on —

19.

Immediate cause of death

Fracture liver

DURATION

2 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Fracture liverDate of op. 6/3/46

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 6/3/46Where did injury occur? Perryville Cecil (City or town) (County) (State)Injured at home, farm, industry, public place (where?) Boat yardMeans of injury Hist Injured at work? YesSignature Gerald C Palmer M.D.Title Deputy Medical ExaminerAddress Harford County M. D. or otherDate signed 6/5/46

(Date rec'd by registrar)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

06030

CERTIFICATE OF DEATH

Reg. Dist. No. 18²

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 31

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years Months Days If less than one day

9. Birthplace

(Town, county, and state) Harford Co., Md

10. Usual occupation

Housework

11. Industry or business

At home

12. Name

Charles M. Burkitt

13. Birthplace

Harford Co., Md.

14. Maiden name

Catherine Dagan

15. Birthplace

Harford Co., Md.

16. Informant

Mrs. J. Wilson Gallbreath

Address

Street, Md.

17. Burial

(Burial, cremation, or removal, which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Emory Cem

Location

Harford Co., Md.

18. Funeral director

J. S. Bailey

Address

Darlington, Md.

June 13, 1946

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Harford

City or town

Street

(If outside city or town limits, write RURAL and give nearest town)

Street No.

No

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

213-01-9903

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 16, 1946, at 2:30 A.M.

1946 to 1946

and that I last saw her alive on June 10, 1946

Immediate cause of death

Pulmonary tuberculosis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

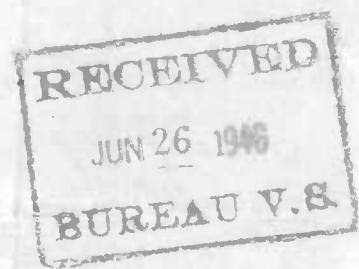
Beaum George

M. D. or other

Address

Cardiff

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1340

06031

CERTIFICATE OF DEATH

Reg. Dist. No. 183

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

8. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

8. (c) If alive, give age

years

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof
(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date rec'd by registrar)

19. (Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH

June 3 1946 at 2:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... to

19...

and that I last saw him alive on June 28 1946

19...

Immediate cause of death

DURATION

Obstruction of trachea

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M
THE CORPORATION LIMITED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

CERTIFICATE OF DEATH

06032

Reg. Dist. No. 185

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

U. Oliver Hill

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male Negro Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) February 11, 1894

6. (c) If alive, give age

years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Haute de Grace

(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

U. P. Hill

12. Name

Haute de Grace, Md

13. Birthplace

Assiana Bellis

14. Maiden name

Haute de Grace, Md

15. Birthplace

Mrs. C. Hall

16. Informant

Warren & Columbia, Sts.

17. Burial

Date thereof June 15, 46

(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory

St. James

Location

Haute de Grace

18. Funeral director

Elmer E. Bullock

Address

Haute de Grace, Md

19. Date rec'd by registrar

June 15

1946

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

City or town

County

(If outside city or town limits, write RURAL and give nearest town)

Street No.

Warren & Columbia, Sts.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 13, 1946, at 9:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 8, 1946, to June 13, 1946,

and that I last saw him alive on June 13, 1946.

Immediate cause of death

Pneumonia and

Pulmonary Tuberculosis

Due to

Due to

Other conditions

Cachexia

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M.D. or other

Address

Haute de Grace, Md

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

06033

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH:

County HagerstownCity or town Bethel

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 daysHospital, institution, or street address where death occurred: 138 Main St.

How long in hospital or institution?

3. (a) FULL NAME

Ada Rosetta Young Hollingsworth4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Charles Agnes7. Birth date of deceased (mo., day, yr.) October 5, 1862 6. (c) If alive, give age years8. AGE: Years 83 Months 7 Days 8 If less than one day hrs. 0 min. 09. Birthplace Hagerstown County (Town, county, and state) None10. Usual occupation None

11. Industry or business

12. Name Ada Rosetta Young13. Birthplace Hagerstown Birthplace Bethel14. Maiden name Mary Elizabeth Cochran15. Birthplace Hagerstown County16. Informant Rosetta HollingsworthAddress Charlottesville, Va.17. Burial Date thereof June 16, 1946 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Little Falls CemeteryLocation Fairston, Md.18. Funeral director Howard K. McLeanAddress Abingdon, Md.

19. 6/15/46 (Date rec'd by registrar) 19. 46 (Date of death)

Priscilla Lowwood (Name of person signing)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HagerstownCity or town Bethel (If outside city or town limits, write RURAL and give nearest town)Street No. 138 Main St. (If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 13 1946 at 11:56 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1946 to June 13 1946 and that I last saw her alive on June 13 1946.Immediate cause of death Acute Myocardial FailureDURATION 12 hrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

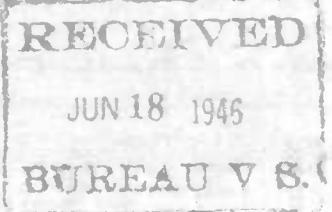
Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Bellair, Md. Date signed 6/14/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-6)

06034

CERTIFICATE OF DEATH

Reg. Dlat. No. 183

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

Dec 6, 1880

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

Retailer Sportswear

11. Industry or business

Sportswear

12. Name

George W. Esominger

13. Birthplace

Ohio

14. Maiden name

Ellen Robison

15. Birthplace

Ohio

16. Informant

Ella Esominger

Address

5115 State Rd

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Jan 10 1946

(month) (day) (year)

Cemetery or crematory

Westview Cem.

Location

Philadelphia, Pa

18. Funeral director

W. Howard West

Address

5115 State Rd

June 19, 1946

(Date rec'd by registrar)

Thomas R. Brown

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 13 1946 at 10:20 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 15 1845 to June 17, 1946

and that I last saw him alive on June 17, 1946

Immediate cause of death Chronic

Nephritis, cl. 2 myocarditis
& circ. 25%

Due to Hernia pleuritis

4 yr. age

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

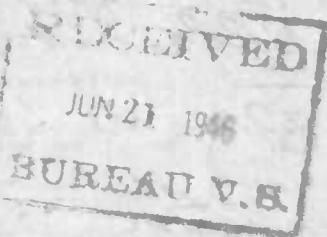
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Norman H. Germill M. D. or other

Address Stewarttown, Pa. Date signed 6/17/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore M

06035

CERTIFICATE OF DEATH

Reg. Dist. No. 180

1. PLACE OF DEATH:

County..... HarfordCity or town..... Edgewood, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Station Hospital, Edgewood Arsenal, Md.How long in hospital or institution? Five hours.

3. (a) FULL NAME

JAMES I. JOHNSON

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

White

Single

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

29 April 1917

8. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

2916

hrs.

min.

9. Birthplace.....

(Town, county, and state) Belle, Missouri

10. Usual occupation.....

U. S. Army

11. Industry or business

#

MOTHER FATHER

12. Name.....

Unknown

MOTHER

13. Birthplace

14. Maiden name.....

Unknown

15. Birthplace

16. Informant.....

U. S. Records

Address

17. Burial, cremation, or removal. Which? Cremation Date thereof June 5, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Greenbaum Funeral Home

Location

Belle, Md.

18. Funeral director

Howard K. McCorison

Address

Abingdon Maryland

19. Date rec'd by registrar

June 5 1946 Marie M. Mouldsdale

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Kansas

County.....

City or town..... Kansas City

(If outside city or town limits, write RURAL and give nearest town)

Street No. 802 Shawnee Avenue

(If rural, give LOCATION)

World War II

2.(a) If veteran, name war.

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH 4 June 19 46 at 3:30 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4 June 19 46 to 4 June 19 46and that I last saw h. in alive on 4 June 19 46Immediate cause of death Toxemia, pulmonaryedema, due to burns, ~~XXIX~~ third
degree, ninety percent of body.

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 4 June 46Where did injury occur? Edgewood Arsenal, Edgewood, Md. (City or town) (County) (State)Injured at home, farm, industry, public place (where?) Edgewood Arsenal

Means of injury

BurnsInjured at work? Yes

23. SIGNATURE

Howard K. McCorison, Reg. No. 180

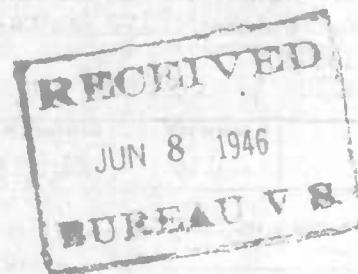
M. D. or other

Address Station HospitalDate signed 4 June 46

RECEIVED BY THE UNITED STATES GOVERNMENT

RECEIVED BY THE UNITED STATES GOVERNMENT

#1



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 852

CERTIFICATE OF DEATH

06036

Reg. Dist. No. 182

1. PLACE OF DEATH:

County.....

Hartford

City or town.....

Bel Air, Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

47 years

Hospital, Institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

G Frank Jones

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

M

6. (b) Name of husband or wife.....

Elizabeth R Cole

7. Birth date of deceased (mo., day, yr.)

July 23 - 1862

8. (c) If alive, give age.....years

8. AGE: Years

83

Months

Days

If less than one day

hrs.

min.

9. Birthplace.....

Forest Hill, Md

(Town, county, and state)

10. Usual occupation.....

Retired Farmer

11. Industry or business

Dan'l W Jones

12. Name.....

M. D.

13. Birthplace

Amanda Ford

14. Maiden name.....

Baltimore, Md

15. Birthplace

16. Informant.....

Mrs Elizabeth R Jones

Address

Bel Air, Md

17. Burial.....

(Burial, cremation, or removal. Which?)

Date thereof.....

(month) (day) (year)

Cemetery or crematory.....

Mt Zion

Location.....

Fountain Green, Md

18. Funeral director.....

Dean & Foster

Address

Bel Air, Md

19. (Date read by registrar)

6/15/46

19

Priscilla Fowle

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md

County.....

Hartford

City or town.....

Bel Air, Md (Rural)

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

26. DATE OF DEATH.....

June 13

1946, at 11A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 1947, to June 1946

and that I last saw h. s. alive on June 12, 1946

Immediate cause of death.....

Cerebral Hemorrhage

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....

M. D. or other

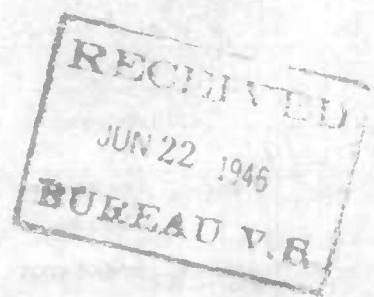
Address.....

Date signed 6/14/46

RECEIVED

JUN 18 1946

BUREAU V.S.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

06038

CERTIFICATE OF DEATH

Reg. Dlat. No. 182

1. PLACE OF DEATH:

County

City or town

Harford

Dobles

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

69

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male White Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age

years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Harford Co., Md

(Town, County, and state)

10. Usual occupation

Electrician

11. Industry or business

House wiring

Robert G. Kelly

12. Name

Cecil Co., Md.

Robert G. Kelly

Cecil Co., Md.

13. Birthplace

Annie Crowl

Chester Co., Penna.

Mrs. Reba Morris

Mrs. Reba Morris

Street, Md., R. R.

Burial

Date thereof

June 20 1946

(Burial, cremation, or removal, if any)

Cemetery or crematory

Harford Co., Md.

Location

H. J. Bailey

Arlington, Md.

Address

July 8, 46 M. C. Clark

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md County

City or town

Dobles

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

Mo

3. (b) Social Security Number

No

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 17

1946 at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 1920 to June 17 1946

and that I last saw him alive on June 10 1946

Immediate cause of death

Coronary thrombosis

DURATION

4 days
2 weeks

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

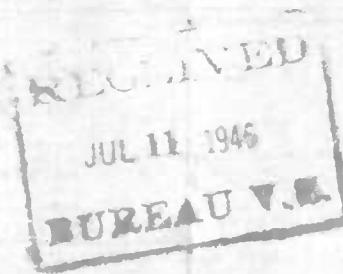
W. E. Gallion

M. D. or other

Address

Dorington

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 830

CERTIFICATE OF DEATH

06039

Reg. Diet. No. 182

1. PLACE OF DEATH:
 County..... Harford
 City or town..... Cardiff
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 6 yrs.
 Hospital, Institution, or street address where death occurred:
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State..... Maryland County..... Harford
 City or town..... Cardiff
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME
 Zua L. Lane

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife..... William H. Lane

7. Birth date of deceased (mo., day, yr.)..... April 19, 1871

8. AGE: Years 75 Months 1 Days 20 If less than one day
 hrs. min.

9. Birthplace..... York Co. Pa.
 (Town, county, and state)

10. Usual occupation..... Housewife

11. Industry or business

MOTHER FATHER
 12. Name..... John T. Boyd
 13. Birthplace..... Chester Co. Pa.

MOTHER
 14. Maiden name..... Rachel Dunlap

15. Birthplace..... York Co. Pa.

16. Informant..... Margaret Lane Boyle
 Address..... Cardiff, Md.

17. Burial
 (Burial, cremation, or removal. Which?) Date thereof..... June 11, 1946
 Cemetery or crematory..... Mt. Nebo cemetery

Location..... Delta, Pa.

18. Funeral director..... Hubert P. Harkins

Address..... Delta, Pa.

June 10, 1946 M. W. Kirk
 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... June 9 1946, at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 2 1946, to June 8 1946

and that I last saw her alive on June 8 1946

Immediate cause of death.....

Cerebral hemorrhage

Due to..... Arteriosclerosis

Hypertension

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

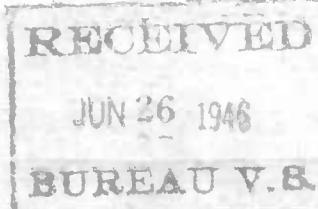
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... Edward St. Hyson
 M. D. or other

Address..... Fawn Grove, Pa. Date signed. 6/10/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BY THE CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 472

06040

185

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County HarfordCity or town Han de Grace, Md.

How long in above place of death?

Hospital, institution, or street address where death occurred:

Harford Memorial Hosp.How long in hospital or institution? 4 days.

3. (a) FULL NAME

William Mackin

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

m w single

6.(b) Name of husband or wife

6.(c) If alive, give age

years

7. Birth date of deceased (mo., day, yr.) March 16, 1891

8. AGE:

Years

Months

Days

If less than one day

55 2 23 hrs. min.8. Birthplace Han de Grace, Md.

(Town, county, and state)

10. Usual occupation rose worker

11. Industry or business

12. Name Joseph Mackin13. Birthplace Ireland14. Maiden name Mary Crane15. Birthplace Maryland18. Informant Hosp. RecordsAddress Han de Grace17. Burial Date thereof 6/12/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Mt. ZionLocation Han de Grace18. Funeral director Mr. PeacingtonAddress Washington St. City19. Date rec'd by registrar June 11 1946

E. L. Louis Jr. S.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Han de Grace

(If outside city or town limits, write RURAL and give nearest town)

Street No. 300 Market St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9 1946 at 2:35 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 5 1946 to June 8 1946 and that I last saw him alive on June 8 1946.Immediate cause of death double hydrocephalus DURATION 2 daysDue to adenovirus lung

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

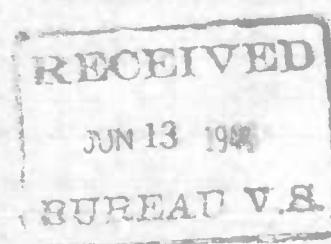
Means of injury

Injured at work?

23. SIGNATURE

E. J. Simon M. D. or other

Address Han de Grace Date signed 6-9-46



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

06041

CERTIFICATE OF DEATH

Reg. Distr. No. 185-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County Harford
City or town Harde de Grace

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 hrs 30 min

Hospital, institution, or street address where death occurred:
Harford Memorial Hospital

How long in hospital or institution? 13 hrs 30 min

3. (a) FULL NAME Margaret Kathleen
Baby Girl McCall

4. Sex f 5. Color or race w. f 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife —

7. Birth date of deceased (mo., day, yr.) 6-22-46 6. (c) If alive, give age — years

8. AGE: Years — Months — Days — If less than one day 13 hrs. 30 min.

9. Birthplace Harford Memorial Hospital, Harde de Grace, Md.
(Town, county, and state)

10. Usual occupation —

11. Industry or business —

MOTHER FATHER 12. Name Nelson Heisler McCall

13. Birthplace Charlestown, Md.

14. Maiden name Margaret Dowdy

15. Birthplace Wilmington Del

16. Informant Nelson McCall

Address Charlestown, Md

17. Burial Burial Date thereof 6-23-46

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Charlestown

Location Charlestown, Md

18. Funeral director Joseph R. Shantz

Address 700th East, Md

19. Date rec'd by registrar June 22 1946 A. L. Lewis M.D.

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County St. Cecil

City or town Charlestown

(If outside city or town limits, write RURAL and give nearest town)

Street No. —

(If rural, give LOCATION)

2. (a) If veteran, name war —

3. (b) Social Security Number —

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-22-46 19 — at 11:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6-22 1946 to 6-22 1946

and that I last saw her — alive on 6-22 1946

Immediate cause of death Pneumonia

Due to —

Due to —

Other conditions —

(Include pregnancy within 3 months of death)

Major findings or operations —

Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) — (County) — (State)

Injured at home, farm, industry, public place (where?) —

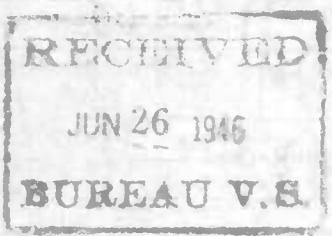
Means of injury — Injured at work? —

23. SIGNATURE Dr. Stevens M.D.

M. D. or other —

Address Harde de Grace, Md

Date signed 6-22-46



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1932

CERTIFICATE OF DEATH

06042-185-
Reg. Dist. No.

1. PLACE OF DEATH: Harford
 County Havre de Grace

City or town (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

314 Bourbon St.

How long in hospital or institution?

3. (a) FULL NAME

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Elsie L. McCommons

7. Birth date of deceased (mo., day, yr.) Oct. 4, 1885 8. (c) If alive, give age 44 years

8. AGE: 60 Years 8 Months 10 Days If less than one day hrs. min.

9. Birthplace Havre de Grace, Md. (Town, county, and state)

10. Usual occupation Matchman

11. Industry or business Retired

12. Name Henry McCommons

13. Birthplace Md.

14. Maiden name Avarilla McCommons

15. Birthplace Md.

16. Informant Mrs. Elsie L. McCommons

Address 314 Bourbon St. City

17. Burial Angel Dell Date thereof June 16, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Havre de Grace, Md.

Location P. Madison Mitchell

18. Funeral director Havre de Grace, Md.

Address Havre de Grace, Md.

19. Date rec'd by registrar June 15, 1946 G. L. Lewis, m. d.

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State Md. County Harford

City or town Havre de Grace (If outside city or town limits, write RURAL and give nearest town)

Street No. 314 Bourbon St. (If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

218-03-8961

MEDICAL CERTIFICATION

20. DATE OF DEATH June 14, 1946 at 2 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 19, 40 to June 14, 1946

and that I last saw him alive on June 14, 1946

Immediate cause of death Pulmonary edema DURATION 180 days

Due to Chronic nephritis

Due to Chronic bronchitis DURATION 5 years

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Frank Ulrich, M.D.

M. D. or other

Address Havre de Grace Date signed June 15



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

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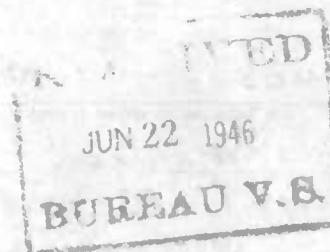
CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County

Harford
Home of Grace

(If outside city or town limits, write RURAL and give nearest town)



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 160-61

CERTIFICATE OF DEATH

06044

Reg. Dist. No. 181

1. PLACE OF DEATH:

County Harford

City or town Aberdeen Proving Ground, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Michael Nisevich

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

8. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) 26 March 1916 8. (c) If alive, give age years

8. AGE: Years Months Days If less than one day
2 24 hrs. min.

9. Birthplace Hayre de Grace, Harford County, Md. (Town, county, and state)

10. Usual occupation.....

11. Industry or business

FATHER 12. Name Stanley J. Nisevich
13. Birthplace Podovia, JugoslaviaMOTHER 14. Maiden name Mary Spear
15. Birthplace Hammond, Indiana16. Informant Stanley J. Nisevich
Address Aberdeen Proving Ground Md
Burial or cremation 17. Date thereof.....

(month) (day) (year)

Cemetery or crematory Everlasting Funeral Chapel
Location 5322 Old Hanover Street, Indiana, Ind18. Funeral director Howard L. McElroy
Address Abingdon Maryland

19. (Date rec'd by registrar) June 29, 1946

Ellie H. Riley
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Harford
City or town Aberdeen Proving Ground
(If outside city or town limits, write RURAL and give nearest town)Street No. Quarters 107
(If rural, give LOCATION) 3148

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 24 June 1946 at 6:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on 19. to 19.

Immediate cause of death Subdural hemorrhage
Atelectasis both lower lungs

DURATION

Due to The sub-dural hemorrhage was spontaneous
not due to accident or injury

Due to Duration: two days

Other conditions (Include pregnancy within 3 months of death)

Major findings or operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

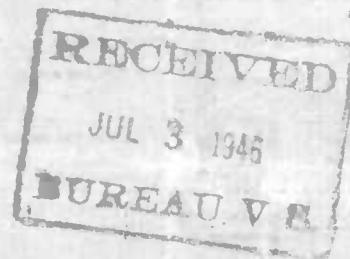
23. SIGNATURE Walter Pick, M.D.

M. D. or other

Address Station Hosp. A.P.G. Date signed 25 June 1946

RECEIVED BY THE UNITED STATES GOVERNMENT

RECEIVED BY THE UNITED STATES GOVERNMENT



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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-2

CERTIFICATE OF DEATH

06045 Reg. Dist. No. 181

1. PLACE OF DEATH:

County

City or town. (If outside city or town limits, write RURAL and give nearest town)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Q 10 #1 Harford Grace Md

How long in hospital or institution?

3. (a) FULL NAME

Cornelius Warner Pickett

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male W. Widowed

6. (b) Name of husband or wife deceased. Magnolia Pickett

7. Birth date of deceased (mo., day, yr.) Aug. 31 - 1869

8. AGE: Years Months Days It less than one day

76 9 9

hrs. min.

9. Birthplace Carroll County

(Town, county, and state)

10. Usual occupation Retired Merchant

11. Industry or business

12. Name Warner Pickett

13. Birthplace Carroll County

14. Maiden name Nelia Hull

15. Birthplace Carroll County

16. Informant C.M. Pickett

Address 1252 20th St. Wash. D.C.

17. Burial Cemetery Date thereof June 17-1946

(Burial, cremation, or removal. Which?)

Cemetery

Location Savage Md

18. Funeral director Floyd Kaiser

Address Laurel Md.

19. June 10 1946 Birtha B. Knight

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.

County Harford

City or town Q 10 #1 Harford Grace Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

none

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 9 1946 1120 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 1945 to June 9 1946, and that I last saw her alive on June 9 1946.

Immediate cause of death

Arthur Pickett

Due to

Cerebral Hemorrhage

Due to

Other conditions

Cachexia

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

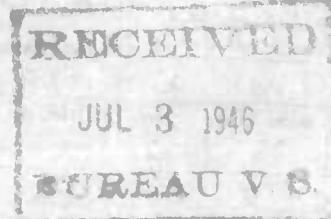
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Charles H. Pickett, Jr.

or other

Address Harford Grace Md. Date signed 6/10/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

CERTIFICATE OF DEATH

06046

Reg. Dist. No. 182

1. PLACE OF DEATH:

County.....

Harford

City or town.....

Cardiff

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

50 yrs

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

David Pyle

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

m

white

Married

6. (b) Name of husband or wife.....

Bertha A. Pyle

7. Birth date of

deceased (mo., day, yr.)

6. (c) If alive, give age.....

years

Aug 13 1879.

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace.....

York Co., Pa.

(Town, County, and state)

10. Usual occupation.....

Salesman

11. Industry or business

Nathan & Pyle

12. Name.....

Harford Co., Md.

13. Birthplace

Caroline Meeker

14. Maiden name.....

Harford Co., Md.

15. Birthplace

Bertha Agnes Pyle

16. Informant.....

Cardiff, Md.

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof.....

(month) (day) (year)

Cemetery or crematory

Slate Ridge Cem

Location

Delta, Pa.

18. Funeral director.....

Hubert P. Hawkins

Address

Delta, Pa.

19. Date rec'd by registrar

July 8, 1946

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

Harford

City or town.....

Cardiff

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 20 1946 at 4:00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 15 1946 to June 20 1946

and that I last saw h. in, alive on June 20 1946

Immediate cause of death.....

Coronary Thrombosis

Due to.....

Coronary Thrombosis

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury

Injured at work?

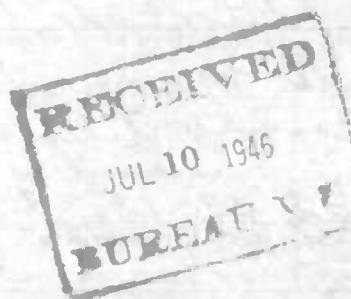
23. SIGNATURE

Joseph A. Hunt M.D.

M. D. or other

Cardiff, Md. Date signed 6/20/46

JUL 10 1946



PLEASE WRITE PLAINLY, WITH ~~US~~ FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06047

CERTIFICATE OF DEATH

Reg. Dist. No.

195-

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? About 40 yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Mary Simone

4. Sex

5. Color of eyes

6. (a) Single, married, widowed, or divorced

Female White Widow

6. (b) Name of husband or wife

Antonio Simone (deceased)

7. Birth date of deceased (mo., day, yr.)

April 23 - 1876

8. AGE:

Years Months Days If less than one day

70 2 24 hrs. min.

9. Birthplace

Italy (Town, county and state)

10. Usual occupation

Housewife

11. Industry or business

Valentino Delario

12. Name

Italy

13. Birthplace

Unknown

14. Maiden name

"

15. Birthplace

Mrs. Billy This

16. Informant

Address 802 Erie St. Han de Grace

17. Burial

Date thereof 6/28/46

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory Mt. ZionLocation Han de GraceFuneral director Pennington & SonAddress Han de GraceDate rec'd by registrar June 28 1946(Date rec'd by registrar) G. L. Lewis M.D.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarpersCity or town Han de Grace (If outside city or town limits, write RURAL and give nearest town)Street No. 802 Erie (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 23 - 1946 at 9:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 10 1942 to June 23 1946,and that I last saw her alive on Jan. 25 1946.

Immediate cause of death

Acute DeliriousHypertensionCerebral HemorrhageDue toToxemiaDue toOther conditions(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Charles J. Kelly Jr. M.D. M. D. or otherAddress Han de Grace Date signed 6/27/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH:

County

City or town

Harford

Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

220 So. Stokes St.

How long in hospital or institution?

3. (a) FULL NAME

Priscilla Singleton

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

white

Married

Stephen J. Singleton

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Oct. 2, 1858

8. AGE:

Years

Months

Days

If less than one day

87

8

7

.hrs. min.

9. Birthplace

Harford Co. Md.

(Town, county, and state)

10. Usual occupation

House Duties

11. Industry or business

Retired

MOTHER FATHER

Thomas Sampson

12. Name

Emily Cren

MOTHER

Md.

13. Birthplace

Md.

14. Maiden name

Mrs. Laura D. Wright

15. Birthplace

220 So. Stokes St

16. Informant

Burial

Date thereof June 11, 1946

(Burial, cremation, or removal. Which?)

Smith's Chapel

Cemetery or crematory

Harford Co. Md.

17. Location

P. Madison Mitchell

18. Funeral director

Havre de Grace, Md.

19. Address

June 10, 1946

A. L. Lewis M.D.

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.

County

Harford

City or town Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

Street No. 220 So. Stokes St.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

2

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 9 1946 at 12¹⁵ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

as of 1946 to June 9, 1946

and that I last saw her alive on June 8, 1946

Immediate cause of death

cardiac failure

DURATION

1 day

Due to

Arteric myocarditis

20 years

Due to

Inflammation of age

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

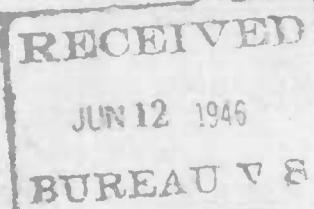
Injured at work?

23. SIGNATURE

M. D. or other

Address

Name of deceased Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 486

06049

CERTIFICATE OF DEATH

Reg. Dist. No. 181

1. PLACE OF DEATH:

County

Fairford

City or town

Aberdeen

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

40 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Rosalie Jane Singleton

4. Sex

5. Color of race

6. (a) Single, married, widowed, or divorced

Female

white

Married

B. (b) Name of husband or wife

Thomas Singleton

7. Birth date of deceased (mo., day, yr.)

Aug 2. 1892

6. (c) If alive, give age

years

8. AGE:

Years

Months

Days

If less than one day

53

8

1

hrs. min.

9. Birthplace

Fairford Co. Md

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Tintor J. Cullens

12. Name

Tintor J. Cullens

13. Birthplace

Maryland

14. Maiden name

Margaret Thompson

15. Birthplace

Maryland

16. Informant

Thomas Singleton

Address

Aberdeen Maryland

17. Burial

Date thereof June 5 1946

(Burial, cremation, or removal, which?)

(month) (day) (year)

Cemetery or crematory

Strose

Location

Aberdeen Maryland

18. Funeral director

Howard K. Metzner & Son

Address

Abingdon Maryland

19. Date rec'd by registrar

June 10 1946

1946

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland County

City or town

Fairford

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH

June 3

1946

at 9:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

act

1945

to

June 3

1946

and that I last saw her alive on

June 2

1946

Immediate cause of death

Cerebral

DURATION

Due to

Carcinoma of uterus

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Ca. of uterus involving

uterus

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

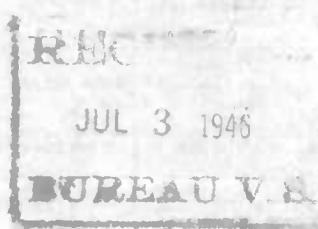
G. J. Gaston Jr.

M. D. or other

Address

Aberdeen

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. **MY**

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 720

CERTIFICATE OF DEATH

06050

Reg. Diat. No. **181**

1. PLACE OF DEATH:

County

**HARFORD
ABERDEEN**

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? **NOT KNOWN**

Hospital, institution, or street address where death occurred:

PHILADELPHIA Road

How long in hospital or institution? —

3. (a) FULL NAME

FRANCIS Andy SUMNER

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

MALE WHITE**Unknown**

6.(b) Name of husband or wife

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

Unknown

8. AGE:

Years

Months

Days

If less than one day

About 55

.... hrs.

min.

9. Birthplace

Unknown

(Town, county, and state)

10. Usual occupation

Unknown

11. Industry or business

MOTHER FATHER

12. Name

Unknown

13. Birthplace

Unknown

14. Maiden name

Unknown

15. Birthplace

Unknown

16. Informant

John G. Tammey

Address

106 Rogers St. Aberdeen Md

17. Burial

Date thereof

June 17-1946

(month) (day) (year)

Cemetery or crematory

None

Location

Aberdeen Md

18. Funeral director

Henry Tammey Sons

Address

Aberdeen Md

19. Date rec'd by registrar

June 17 1946

19.

Nellie B Riley

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State **Unknown** County **Unknown**City or town **Unknown** (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

579-12-6829

MEDICAL CERTIFICATION

20. DATE OF DEATH **JUNE 13** 1946 at 11:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to..... 19.....

and that I last saw h..... alive on..... 19.....

Immediate cause of death

**CEREBRAL HEMORRHAGE
TRAUMATIC**

DURATION

Due to.....

Due to.....

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results **None**

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide **ACCIDENT**

Date of

June 13, 1946Where did injury occur? **ABERDEEN HARFORD MD**

(City or town)

(County)

(State)

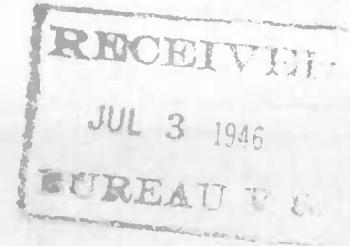
Injured at home, farm, industry, public place (where?) **PUBLIC ROAD**Means of injury **STRUCK BY TRUCK** Injured at work? **NO**

23. SIGNATURE

J. G. Tammey, M.D.

AC. DEP. MED. Examiner

Address **Aberdeen, Md.** Date signed **June 14, 1946**



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 181

06051

CERTIFICATE OF DEATH

Reg. Dist. No. 180

1. PLACE OF DEATH:

Harford County

Edgewood, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Station Hospital, Edgewood Arsenal, Md.

How long in hospital or institution? Ten hours

3. (a) FULL NAME

Jose M. Velardez

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Single

6. (b) Name of husband or wife: ***

7. Birth date of deceased (mo., day, yr.) 16 April 1920

8. AGE: Years	Months	Days	If less than one day
26	1	18	hrs. min.

9. Birthplace: Isleta, New Mexico
(Town, county, and state)

10. Usual occupation: U S Army

11. Industry or business: 10

12. Name: Jose J. Velardez

13. Birthplace: Unknown

14. Maiden name: Unknown

15. Birthplace: Unknown

16. Informant: U S Records

Address: Transportation

(Burial, cremation, or removal, which?) Date thereof: June 6, 1946
(month) (day) (year)

Cemetery or crematory: Jose M. Velardez

Location: Isleta, New Mexico

18. Funeral director: Howard K. McCormick

Address: Abingdon Maryland

19. Date: June 6, 1946
(Date rec'd by registrar) Name: M. M. Monkdale
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: New Mexico County:

City or town: Isleta (If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION) ★, 4

2. (a) If veteran, name war: World War II

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4 June 1946 at 8:26 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4 June 1946 to 4 June 1946 and that I last saw him alive on 4 June 1946.

Immediate cause of death: Toxemia, pulmonary edema

Due to: burns, third degree, ninety percent of body.

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of: 4 June 1946

Where did injury occur: Edgewood Arsenal, Edgewood, Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where): Edgewood Arsenal

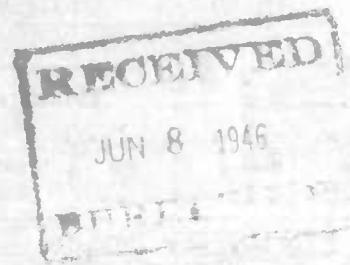
Means of injury: Burns Injured at work? Yes

23. SIGNATURE: Joseph Wm. Kue Cap. MC
M. D. or Other

Address: Station Hospital Date signed: 4 June 1946

RECEIVED BY TELETYPE STATE APPLIANCE
AND TELETYPE CORP.

Belle or Bell City



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06052

CERTIFICATE OF DEATH

Reg. Dist. No. 183

1. PLACE OF DEATH:

County..... *Hanford*City or town..... *Pylesville*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

4. Sex *Male* 5. Color or race *White* 6. (a) Single, married, widowed, or divorced *Single*

8. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) *Feb 6 1942*8. AGE: Years *7* Months *4* Days *2* If less than one dayhrs. *0* min. *0*9. Birthplace *Pylesville Md*

(Town, county, and state)

10. Usual occupation *None*11. Industry or business *None*12. Name *John E Webster Jr*13. Birthplace *Pylesville Md*14. Maiden name *Elvina Bortol*15. Birthplace *Pylesville Md*16. Informant *John E Webster Jr*Address *Pylesville Md*17. Burial, cremation, or removal (Which?) *Burial* Date thereof *June 21 1942*

(month) (day) (year)

Cemetery or crematory *St. Marys*Location *Pylesville Md*18. Funeral director *Howard West*Address *5 and 6 Pine St*19. (Date rec'd by registrar) *June 21 1942*

Thomas R. Brown

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH *June 18 1942*21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *7:00* 19.42, to *6:00* June 18 19.42and that I last saw him alive on *June 18 19.42*Immediate cause of death *Hydrocephalus*Due to *Brain Abscess*

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

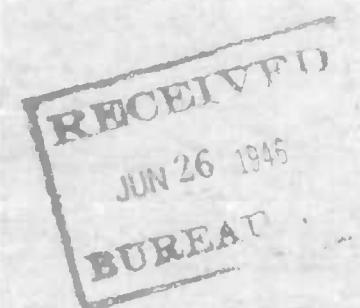
Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE *Donald G. Hunt M.D.*

M. D. or other

Address *Caretta Md* Date signed *6/29/42*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CITY OF BOSTON, MASSACHUSETTS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 44

061153

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH:

County Harford CoCity or town Holme de Grace

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

William Henry Witte4. Sex M5. Color or race white6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Irene Witte6. (c) If alive, give age 20 years7. Birth date of deceased (mo., day, yr.) april 15 1923

8. AGE:

Years 23Months 1Days 27

If less than one day

hrs.

min.

9. Birthplace Baltimore

(Town, county, and state)

10. Usual occupation Riveter11. Industry or business Glen L. Martin

MOTHER FATHER

12. Name William H. Witte13. Birthplace Baltimore14. Maiden name Mary Stewart15. Birthplace Baltimore16. Informant Mary WitteAddress 633 Linden Lane17. Burial Burial

(Burial, cremation, or removal, Which?)

Date thereof 6/15/46
(month) (day) (year)Cemetery or crematory BaltimoreLocation Baltimore Md18. Funeral director William Cook Inc.Address St. Paul & Preston St.19. Date rec'd by registrar June 12 1946(Date rec'd by registrar) 6-2 Lewis

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Holme de Grace

(If outside city or town limits, write RURAL and give nearest town)

Street No. 633 Linden Lane

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH June 12 1946

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 1 1946 to June 12 1946and that I last saw him alive on June 12 1946

Immediate cause of death

Hodgkin'sDue to Disease.Due to InduratedOther conditions Indurated

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

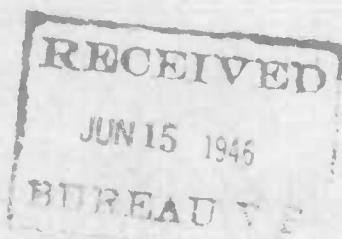
Injured at work?

23. SIGNATURE Charles J. Kelly Jr.

M. D. or other

Address 1717 Charles St. Baltimore Md 6/12/46

Date signed



✓ PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 25

CERTIFICATE OF DEATH

Reg. Dist. No. 183

06054

1. PLACE OF DEATH:
County *Harford*
City or town *Jarrettsville*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Sophia Matilda Junkhan

3. (b) Social Security Number

*None*4. Sex *Female* 5. Color or race *white* 6. (a) Single, married, widowed, or divorced *married*7. Birth date of deceased (mo., day, yr.) *Sept 25 1861* 6. (c) If alive, give age *85* years8. AGE: Years *85* Months *4* Days *3* If less than one day9. Birthplace *Jarrettsville* (Town, county, and state)10. Usual occupation *House Wife*11. Industry or business *Christian S. Sivars*12. Name *Eliza*13. Birthplace *Germany*14. Maiden name *Martha Harwick*15. Birthplace *Germany*16. Informant *Joseph Z. Junkhan*Address *Forest Hill, Md.*17. Burial *Wm. Watters Memorial* Date thereof *June 12 1946*

(Burial, cremation, or removal. Which?)

Cemetery or crematory *Cooptown, Md.*Location *Cooptown, Md.*18. Funeral director *Martin G. Kurtz*Address *Jarrettsville, Md.*19. Date rec'd by registrar *June 12 1946* Thomas P. Brown

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)State *Md.* County *Harford*City or town *Jarrettsville* (If outside city or town limits, write RURAL and give nearest town)Street No. *11* (If rural, give LOCATION)

2.(a) If veteran, name war

MEDICAL CERTIFICATION

2D. DATE OF DEATH *June 10, 1946* at *12:58 P.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 25, 1945, to June 9, 1946 and that I last saw her alive on *June 9, 1946*Immediate cause of death *Jaundice* DURATION *5 days*

Branchial pneumonia

Due to *Cardiac decompensation?*Due to *Hypotension*

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Charles G. Jeff MD

MD or other

Address *Street, Md.* Date signed *6-11-46*

RECEIVED
JUN 20 1946
BUREAU V. S.